JOINING FORCES Joining Families

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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

Home Visiting: Research Review and FAP Implications

The effectiveness of home visiting in preventing child maltreatment is yet to be determined.

James E. McCarroll, Ph.D., and Robert J. Ursano, M.D.

A series of articles on Hawaii's Healthy Start Program was recently featured in *Child Abuse & Neglect.*[1-4] The Healthy Start Program (HSP) is a national prevention program for families at risk for child maltreatment. These articles raise important research questions for Army home visiting programs and Army professionals charged with their oversight.

The articles in *Child Abuse & Neglect* were based on a three-year follow-up of home visiting of at-risk families on the island of Oahu, HI. The research methodology was a randomized trial (see *'Research Into Practice: Useful Terminology'* in this issue of *JFJF* for a discussion of *randomized trial* and other technical terms in this article). The first study[1] addressed whether home visiting prevented child maltreatment. The second study[2] examined the impact of home visiting on parental risk factors (e.g., maternal mental health, substance abuse, partner violence) and whether the intervention affected a mother's interest in and utilization of community services to address risk factors. The third study[3] investigated the relationship between parent and child characteristics and mothers' reports of child maltreatment in the first three years of the child's life. An invited commentary summarized the three studies and provided suggestions for further research.[4]

The three studies examined the same study sample, 643 at-risk families enrolled in HSP from November 1994 to December 1995 in six home visiting programs. Families were identified as at-risk by a variety of sources: information from prenatal care providers, review of the mother's medical record, and assessment at the hospital when the child was born. A semi-structured assessment instrument, the Kempe Family Stress Checklist.[5], also determined risk. Family enrollment was voluntary. The study randomly assigned families to either the HSP (n=373) or to a control group (n=270). Home visits were conducted in the HSP group by paraprofessionals working under professional supervision. All home visitors had a high school diploma. Supervisors had a master's

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In this Issue

This issue highlights the potential and the limitations of two important family violence topics and interventions—home visiting and batterer typologies. Because home visiting is one of the Army's primary approaches to the prevention of child abuse and neglect, it is important to be familiar with its research implications outlined in 'Homevisiting: Research Review and FAP Implications.' In our literature review of batterer typologies, 'Where Are We on the Road to Developing Batterer Typologies?', we offer a research perspective on the popularization of these classifications as a means of improved identification and treatment of abusers

An interview with LTC James Jackson, Senior Policy Analyst in the Department of Defense (DoD), Office of the Deputy Under Secretary of Defense (Military Community & Family Policy), addresses the research recommendations of the Defense Task Force on Domestic Violence (DTFDV) and how DoD seeks to implement them.

Two articles, one on research terminology and a new column on research website resources, support our mission to strengthen your knowledge and interest in family violence research. We welcome your feedback on subjects you would like to learn more about and how JFJF is helping you meet your FAP objectives.

On behalf of our editorial staff, we wish you, your family and the community in which you work a joyous holiday season and healthy and happy New Year. *—James E. McCarroll, Ph.D., Editor-in-Chief*

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The study showed the same risk factors are associated with child maltreatment regardless of homevisiting.

degree in a public health, health, or a human service field and three years experience in client service and administration or a bachelor's degree and five years of relevant experience.

Home visitors were given five weeks of initial core training and additional training including explicit examples of how parental risks might be linked to home visiting goals and intervention activities. They provided a range of services to help parents address existing crises, to model problem-solving skills, and to access services (e.g., income, nutrition, domestic violence, parental substance abuse and poor mental health). They also provided parenting education, modeled effective parent-child interaction, and ensured that the child has medical care. Services were directed to the mother and the father, if possible. The HSP model called for 3–5 years of home visiting in which families who were enrolled at the initial level were visited weekly. There were explicit criteria for promoting the family to a higher level based on increased family stability and identification of a positive support system. With promotion to higher levels, the frequency of home visiting was decreased to biweekly, monthly and quarterly.

Control families did not receive the home visiting intervention, but were evaluated using the same methods as HSP families. Outcome data were collected in annual maternal interviews using self-reports of abuse and standardized measures, observations of the home environment, and records indicative of child abuse and neglect.[1]

Child maltreatment was defined primarily by the mother's report of her own psychologically and physically abusive behavior toward the child on the Parent-Child Conflict Tactics Scale (CTS-PC)[6,7]. The authors were mainly interested in identifying severe physical assault and assault on the child's self-esteem. Factor analysis (a method for grouping variables) of the CTS-PC showed that severe physical abuse included: burned or scalded the child on purpose, grabbed child by the neck or choked, threw or knocked down the child, and hit child with fist or kicked hard. Assaults on the child's self-esteem included items normally considered psychologically abusive (called child dumb or lazy, mother said she would leave child, and swore or cursed at the child) plus one physical abuse item (slapping the child on the face, head, or ears). Because of the inclusion of one physical abuse item with psychologically abusive items, the authors called this cluster assaults on the child's self-esteem. These items reflected maternal behavior that was demeaning and potentially damaging to the child's developing sense of self-worth. Official records of child maltreatment were also used, but the number of reports was very low and hence may have underestimated child maltreatment incidents.

At the end of the three-year evaluation, the home-visited and control groups did not differ significantly on either maternally reported child abuse or substantiated reports of child maltreatment. There was a modest impact in preventing child neglect.[1] The program had no significant effect on the mothers' desire for and use of community services. Also, home visiting had little impact on parental risks for child maltreatment in the first three years of a child's life.[2] *The study showed the same risk factors are associated with child maltreatment regardless of home visiting.* Severe child physical assaults were significantly associated with maternal depression, with the mother having no partner, and the mother's involvement in partner violence (as a perpetrator, not solely as a victim).[3]

In addition, both the child's age (highest for 2-year olds) and the child being small for gestational age (SGA) were related to severe child physical assaults. Interestingly, severe

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At the end of the three-year evaluation, the home-visited and control groups did not differ significantly on either maternally reported child abuse or substantiated reports of child maltreatment. There was a modest impact in preventing child neglect.

physical abuse was not associated with the mother's age, education, race, parity, or household income level.

Assaults on the child's self-esteem were associated with maternal depression, the mother having no partner, the mother's involvement in partner violence, illicit drug use, the child's age (increased over time from year 1 to year 3), and the mother's perception of the child's demands.[3] (The child's demand level was measured by mother's assessment of the child's temperament and behavior.)

There were numerous findings related to the role and performance of the home visitor. It appeared from HSP records that home visitors might have lacked skills, training, and supervision. Home visitors seldom noted concern about possible child maltreatment[1] or parental risk factors for child maltreatment.[2] Despite the fact that home visiting services were to have been developed based on a case plan that addressed the risks identified in an assessment interview, the authors found that many programs drifted from their original intent. Most families had only one or two goals and these were sometimes broadly stated (e.g., "To be happy!"). These were seldom translated into measurable objectives. For this reason, home visiting activities could not be linked to the achievement of family goals and objectives. Overall, there was also no significant program effect on any of the major parental risk factors for child maltreatment. One of the responsibilities of the home visitor was to recognize the need for professional interventions and to make appropriate referrals. There was little evidence that home visitors were alert to the mothers with the highest levels of abusive behavior. Often, home visitors neither developed a plan to address important factors in the life of the family, nor linked home visiting activities to family goals and objectives.[2]

Chaffin's commentary[4] asks whether it is time to re-think home visiting as a mechanism to reduce child maltreatment and emphasized the following points. There is a need for randomized clinical trials in psychosocial research. While there are government requirements for data from randomized clinical trials to demonstrate the safety and effectiveness of food, drugs, and medical (even veterinary) treatment, no such requirements exist for psychosocial interventions and there is no approving agency to certify their effectiveness. Practitioners are accredited, but interventions are not. Child abuse prevention programs are often based upon and justified by advocacy, theory, fashion, guesswork, weak program evaluations and hope. Chaffin addresses how science values skepticism and facts, whereas advocates often have a pre-determined agenda and seek facts that buttress that agenda. The price paid for this is often a high level of funding, a sense of mission among the practitioners, and a willingness to accept evaluation data only if the results are positive.

The following are among Chaffin's interpretations[4] of these studies.

- Partner violence, substance abuse, and parental depression are strong risk factors for future child maltreatment. However, these are the areas that home visitors most often feel least equipped to address.
- Focusing the efforts of home visitors on the known risk factors of the clients may be a better strategy for reducing child maltreatment than the empowerment philosophy. Empowerment models may serve clients poorly by requiring them to self-assess their own risks and intervention needs accurately in order to receive help.
- Empowerment models have strengths that should not be lost. Among these strengths are: establishing collaborative relationships, securing client motivation and buy-in, and avoiding authoritarian service styles that drive clients away.

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Strong Risk Factors for Severe Child Physical Maltreatment[4]

- Parental depression
- Mother having no partner
- Mother involved in violent relationship
- Child's age
- Child small for gestational age

Strong Risk Factors for Assaults on Child's Self-Esteem[4]

- Maternal depression
- Mother having no partner
- Mother involved in violent relationship
- Mother's illicit drug use
- Mother's perception of child's demands
- Child's age

Where Are We on the Road to Developing Batterer Typologies?

Classification of abusers may be a step on the road to improving treatment; however, for this approach to be successful there must be interventions that can be matched to the different types of batterers.

James E. McCarroll, Ph.D.

One of the goals of the Army Family Advocacy Program (FAP) is to provide treatment to victims and offenders in domestic violence. Classification of abusers may be a step on the road to improving treatment; however, for this approach to be successful there must be interventions that can be matched to the different types of batterers. Researchers have attempted to develop batterer typologies based on personal and marital history, personality, current behavior, and physiological measures. Much of this research has been highlighted in the popular media and new studies continue to appear in the scientific literature.

The first report of the Defense Task Force on Domestic Violence (DTFDV) recommended that the military differentiate types of abusers and abusive situations and "determine whether currently available typologies (e.g., Holtzworth-Monroe typology) are a good fit with military populations" (http://www.dtic.mil/domesticviolence). The "one size fits all" approach to treatment is no longer sufficient. Matching offender characteristics to treatment interventions is the goal. The purpose of this article is to present highlights of some recent batterer typology research, to urge caution about the use of simple typologies and to underscore the importance of reliable assessment and matching any typology of offenders with specific treatment interventions. We hope this information will enable you to more carefully scrutinize research on batterer typologies and help you identify possible avenues of research to consider and pursue.

An early review of the literature on batterers identified two major types of abusers: dominant and dependent.[1] The dominant abuser was characterized as a tyrant who had antisocial traits, perpetrated the most severe violence, used fear to control his partner, showed little remorse, and wanted his wife to care for and nurture him. The dependent abuser was often characterized as a person who was chronically resentful and had trouble expressing it, abused alcohol, wanted a wife who was dependent upon him, and was remorseful about his violence. The dichotomy between dominant and dependent abusers is only relative since dominance and dependence were not measured directly, but inferred from a variety of sources such as personality measures, personal reports, observations, and history.

Empirical studies have also been done to replicate or extend the previous findings. In one study, psychological variables were used to construct a batterer typology based on data from 182 men assessed for admission into a male batterer treatment program.[1] Using a statistical technique to group and combine variables (e.g., depression, anger, generalized violence, severity of violence, attitudes toward women, and alcohol use), three types of abusers were identified.

- The *family-only aggressors* reported low levels of anger, depression, and jealousy, and tended to suppress their feelings.
- The *generally violent aggressors* were the most likely of the three to report having perpetrated violence outside the home. They had relatively low or moderate levels of depression and anger, their violence was usually associated with alcohol use, and they were frequently the most severely violent.
- The *emotionally volatile aggressors* had the highest levels of anger, depression, and jealousy. They were severely violent less often than the generally violent aggressors, but were the most psychologically abusive and least satisfied in their relationship.

Another extensive review of the characteristics of male batterers recommended

Five Types of Batterer Typologies

- Dominant *versus* dependent[1]
- Family only Generalized aggressors Emotionally volatile aggressors[1]
- Family only Dysphoric/borderline Generally avoidant and anti-social[2]
- Decreased heart rate (Type 1) *versus* Increased heart rate (Type 2)[5]
- Impulsive *versus* Intentional[9]

In 1995, a new type of batterer classification model was developed based on experimental studies of heart rate changes following an experimental interpersonal conflict exercise in a laboratory setting.

three different classifications of batterers: family-only, dysphoric/borderline personality, and generally violent/antisocial. [2]

Researchers hypothesized the behaviors of each group:

- The *family-only group* could be expected to engage in the least severe marital violence and be the least likely to engage in psychological and sexual abuse. These men are the least likely to engage in violence outside the home, to have legal problems, or to have personality disorders or mental illness. They may comprise about 50% of battering men.
- The *dysphoric/borderline batterers* are expected to engage in moderate to severe wife abuse including psychological and sexual abuse. Some extramarital violence and criminal behavior might be found and they are the most likely to be psychologically distressed, emotionally volatile, have personality disorders, and problems with drug and alcohol abuse. They estimated that this group would comprise 25% of batterer samples.
- The *violent and antisocial* batterers are expected to engage in moderate to severe marital violence including psychological and sexual abuse, have the most extramarital aggression and the most extensive criminal history, have problems with the law, alcohol and drug abuse, and antisocial behavior. They estimated that this group would also comprise 25% of batterer samples.

In an attempt to validate these categories derived from literature review, researchers conducted a study of 102 violent husbands and 62 non-violent husbands.[3]. The study confirmed the three classifications (referred to as the Holtzworth-Monroe and Stuart[2] classification), but also found evidence of a fourth type. The fourth group was called *low-level antisocial*, whose members were described as intermediate between the family-only and the generalized violence/antisocial group.

Batterer classifications have also been studied as a variable for predicting reassault. Researchers conducted a large-scale study aimed at improved prediction of spousal reassault of 840 men in batterer treatment programs in four US cities over a 15-month follow up period.[4] The study used a combination of variables including batterer typologies. The risk variables included: 1) risk markers (static variables that can be readily observed and assessed at intake such as unemployment, substance abuse, and other background variables); 2) risk assessment instruments (measures using multiple risk markers to calculate a score that reflects the degree of risk); 3) batterers classifications based on personality characteristics, behavior, clinical assessment or statistical clustering of variables that are highly associated with each other). The study found that using these classifications in the prediction model did not improve the prediction of spouse reassault. Researchers concluded that batterer typologies based on psychological assessments to determine the extent of intervention might not be very useful. For a complete discussion of the issues of batterer typologies raised here, we recommend you obtain this reference at http://www.ncjrs.org/pdffiles1/nij/grants/202997.pdf .

In 1995, a new type of batterer classification model was developed based on experimental studies of heart rate changes following an experimental interpersonal conflict exercise in a laboratory setting.[5] This research has received much media attention[6]. The study was conducted with 61 married couples with a previous history of domestic violence. [5] They found that violent husbands whose heart rate *decreased* following the interpersonal conflict exercise (Type 1 batterers) were more verbally aggressive towards their wives than those men whose heart rate *increased* (Type 2 batterers). Type 1 batterers were different from the Type 2 batterers in a variety of ways. The Type 1 men were more belligerent, contemptuous and angry. While they were not more violent in their marriages than the Type 2 batterers, they were generally more violent outside the marriage toward friends, strangers, coworkers, and bosses. They were also more likely to have witnessed physical violence between their parents and to be assessed as antisocial, drug dependent, aggressive, and sadistic on a personality measure. The results supported the pattern previously found of severely abusive men who were violent outside the relationship and another group that was only violent in the marriage. The authors believed that their heart rate findings supported the existence of a physiological marker that could potentially serve as an index for developing a batterer typology.

In order to determine the strength of

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The criminal justice system has been receptive to the idea that classifications of batterers might help to determine appropriate interventions rather than viewing all batterers as similar.

We conclude that there has not yet been a classification (typology) model that has demonstrated a clear clinical or research benefit for improved batterer identification and treatment.

research findings, cross-validation is required. In typology research, this means using the same methods with different samples of aggressive men and determining if the findings are stable across studies. There have been at least two attempts at replication of the Type 1 and Type 2 batterers. In one study, similar heart rate distinctions were found in male batterers.[6] One small group (Type 1 batterers) showed a decreased heart rate while the remainder (Type 2) showed an increased heart rate during a marital conflict interaction. However, the findings about behavior were not confirmed. There were no differences between the groups on measures of marital violence, personality, drug dependence, criminality, general violence, behavior during marital interactions, or relationship stability. Thus the typology was not confirmed. The author of the original study of Type 1 and Type 2 batterers responded by pointing out that this study, which attempted to replicate findings, failed to use a high marital conflict discussion that which may be necessary to show the heart rate decrease effect.[7]

A second attempt to replicate the Type 1 and Type 2 batterers also failed to confirm the original findings.[8] No significant differences were found between the Type 1 and Type 2 batterers on their measures of antisocial personality, psychopathy, psychological abuse, general violence, or emotional aggression. This study concluded that further research was needed before this typology based on heart rate physiology would be of utility.

Classifying violence as impulsive versus intentional is the basis for yet another male batterer typology model.[9] Using this distinction, certain male batterers have been found to be more violent in response to threats or frustrations (reactive persons) than those whose violence is planned, methodical, and perpetrated without much external stimulation (proactive persons). In this study, 60 partner-violent men were reliably categorized (62% reactive and 38% proactive). The proactive men were more dominant and less angry during a 10-minute partner interaction, were more antisocial and aggressive and less dependent, and more frequently classified as psychopathic. Importantly, these authors discussed the convergences between the two types of batterers as well as the differences. While they did caution readers that it was too early to make definitive statements about client (batterer)-treatment matching, they did note that previous literature had suggested that reactive partner-violent men may respond best to anger management-based treatment while proactive partner-violent men may respond best to structured cognitive behavior treatments focused on changing the contingencies for the violence.

The criminal justice system has been receptive to the idea that classifications of batterers might help to determine appropriate interventions rather than viewing all batterers as similar. However, some authors have concluded that behavioral and psychological classifications of batterers do not offer much assistance compared with classifications based on abuser demography, criminal history, and substance abuse.[10]

We conclude that there has not yet been a classification (typology) model that has demonstrated a clear clinical or research benefit for improved batterer identification and treatment. This research is very complex and we have hit only the high points of several articles. Typology research will certainly continue. We would be interested in knowing if and how your community has used a typology approach in dealing with abusers and if you believe your community offers an opportunity for such research.

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Research Recommendations of the Defense Task Force on Domestic Violence

The research priorities should be useful for service providers interested in planning domestic violence research in a military environment.

John H. Newby, DVW

The Defense Task Force on Domestic Violence (DTFDV) was established by Congress to study domestic violence in the military and to make recommendations to improve the Department of Defense's (DoD) response to domestic violence (Initial Report, DTFDV, 28 February 2001). Research recommendations were presented in the first report (pp. 102–105) and reiterated in the final recommendations (Third Year Report, DTFDV, 2003, Appendix A, p. 154).

The DTFDV made three recommendations and established seven research priorities. The three recommendations are to:

- Partner with the National Institute of Justice (NIJ) and the Centers for Disease Control (CDC) to further articulate a domestic violence research agenda and organize scientific community-wide requests for applications and a peer review processing of proposals.
- Facilitate and encourage the publication, in peer-reviewed journals, of completed military domestic violence research.
- Avoid disrupting the funding of research into the causes, consequences, and interventions for domestic violence in the military that might result from new funding mechanisms for research.

The seven research priorities are to:

- Differentiate the different types of abusers and the different types of abuse situations.
- Determine what interventions work best for offenders and what interventions work best for victims.
- Clarify how well the military specific approach to domestic violence is working and where it could be modified.
- Determine the actual versus reported prevalence of domestic violence.
- Determine which approaches to domestic violence prevention work and for whom.
- Evaluate the knowledge and consistency of key players (e.g., law enforcement, medical personnel, chaplains) in the response to domestic violence.
- Determine: (a) the efficacy of using marital type counseling to intervene in low-level domestic violence cases, (b) gender differences and similarities in the use of violence; and (c) the impact of the lack of confidentiality on the disclosure of domestic violence and victim safety.

Broad research recommendations such as these are generally best approached by a series of smaller studies. Recent research has suggested that some of these recommendations are more feasible than others. Determining the effectiveness of specific intervention strategies will be the most challenging. Studies drawing upon the interaction and responses of key personnel involved in the prevention and treatment of domestic violence may be the most readily accomplished.

The Army Family Advocacy Research Subcommittee (FARS) is often asked what topics on family violence are of interest to the Army. The FARS does not maintain a list of Army research topics or priorities. Its goal is to support worthwhile research projects that contribute to the advancement of knowledge on family violence in the Army. There is virtually no limit to the topics for family violence research as long as the study is relevant to the needs of the Army and is well designed.

The military services offer an excellent environment within which to implement domestic violence research. Such research can be strengthened by collaborations with local and national domestic violence prevention and treatment programs. Consistent with its mission, especially concern about victim safety and improvements in domestic violence prevention and treatment interventions, the DTFDV research recommendations suggest topics for addressing domestic violence in the military services. The research priorities should be useful for service providers interested in planning domestic violence research in a military environment.

Department of Defense (DoD) Family Advocacy Research Initiatives

John H. Newby, DSW

To update our readers with the latest information on DoD's approach to the DTFDV research recommendations, we present an interview conducted by John H. Newby with LTC James N. Jackson, Ph.D, Senior Policy Analyst, Family Violence Policy Office, Office of the Deputy Under Secretary of Defense for Military Community and Family Policy.

Dr. Newby: In the first year report of the Task Force, there were several recommendations made for domestic violence research. Could you give me an update regarding the Task Force's research recommendations?

LTC Jackson: DoD met with representatives of the National Institute of Justice (NIJ) and the Center for Disease Control (CDC) and agreed to continue discussing the possibility of establishing a research agenda. The DoD subsequently met with NIJ to discuss the feasibility of DoD's involvement in the ongoing National Crime Victimization Survey or replication of the National Violence Against Women Survey. DoD opted to fund its own replication of the National Violence Against Women Survey (Tjaden and Thoennes, 2000). The survey will:

- Provide reliable estimates of the prevalence of domestic violence;
- Provide descriptive data on victims and their offenders;
- Provide descriptive data on the physical, psychological, and social consequences of violent victimization;
- Examine links between threats of violence and actual occurrences of violence;
- Examine links between victimization, fear of violence, and coping strategies;
- Examine how victims respond to specific kinds of victimization; and
- Provide comparable data on the experiences of members of the military community to permit comparisons with a matched civilian sample.

DoD did not endorse establishing a stand-alone domestic violence research program. Instead DoD believes that domestic violence research should be given more favorable consideration by its existing medical, human resources, and quality of life research programs.

Dr. Newby: The National Violence Against Women Survey provided information about rates and the prevalence of violence against women. How will DoD's replication of the study differ from what has already been done and how will it move the field along?

LTC Jackson: The DoD is as much interested in establishing a statistical basis for comparing the military with its civilian counterparts as it is in understanding the many factors that may be unique to the military. This replication represents a real opportunity to study the prevalence of domestic violence in the military.

Dr Newby: Will the replication be only about domestic violence in the military?

LTC Jackson: Yes.. There will be a military sample comprised of active duty military females and non-active duty female spouses of active duty males. The analysis of prevalence will contrast the rates for the military sample with those of the civilian sample from the original National Violence Against Women Survey.

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Lieutenant Colonel James N. Jackson
Medical Service Corps, United States Army

Lieutenant Colonel James N. Jackson is a Senior Policy Analyst in the Office of the Deputy Under Secretary of Defense (Military Community & Family Policy), and is responsible for helping implement many of the recommendations previously made by the Defense Task Force on Domestic Violence. He holds a BA in Sociology from the City College of New York, a MS in Social Work from Columbia University, and a PhD in Social Work from The Catholic University of America. He served as Director, Offender Accountability, Defense Task Force on Domestic Violence, Arlington, VA. Prior to that assignment he was Chief, Army Community Service Division, U.S. Army Community and Family Support Center, Headquarters, Department of the Army, Alexandria, VA.

DoD did not endorse establishing a stand-alone domestic violence research program. Instead DoD believes that domestic violence research should be given more favorable consideration by its existing medical, human resources, and quality of life research programs

Dr. Newby: What is the current status of this initiative in DoD?

LTC Jackson: We have hired Systems Research and Applications Corporation for the project. They are currently working to resolve a number of methodological issues that will smooth the way toward carrying out the project.

Dr. Newby: Are there any other actions underway regarding the research recommendations of the Task Force?

LTC Jackson: Yes, Dr. Cris Sullivan from Michigan State University is currently involved in a study of the impact of expanded victim advocacy programs in the Services.

Dr. Newby: How are you keeping the field informed about your work and is there a mechanism for researchers at installations to get involved?

LTC Jackson: We meet quarterly with the DoD and Services' Family Advocacy Program Managers to discuss the status of implementation efforts within our office. We ask them to have their installation counterparts encourage researchers to discuss their research ideas and interests, and assist them in garnering chain of command support to bring their ideas to fruition.

Reference

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Websites: National Institute of Justice www.opj.usdoj.gov/nij.

Websites of Interest

Our new column, *Websites of Interest*, highlights internet sites with valuable information and resources related to family violence. *JFJF* would like to suggest the following for your review:

- National Clearinghouse on Child Abuse and Neglect Information (http://nccanch.acf.hhs.gov). This site, part of the U.S. Department of Health and Human Services, Administration for Children and Families, offers information for child maltreatment professionals in English and Spanish. This site offers free publications, a clearinghouse for publications, information on legal issues, state-specific guidelines, child maltreatment statistics, announcements of professional meetings and information on grants and funding.
- National Center on Shaken Baby Syndrome (SBS) (http://www.dontshake.com.) provides information for parents, care givers, medical and legal professionals, investigators and educators. There are news releases and prevention materials. The site lists the names and addresses of their worldwide advisory board of experts in the field. Due to the importance of SBS in the Army's child maltreatment prevention effort, we highly recommend perusing this site and using it for your prevention programs.
- The National Institute of Neurological Disorders and Stroke (NINDS) of the National Institutes of Health (NIH) provides information on SBS (http://ninds.nih.gov/health_and_medical/disorders/shakenbaby.htm) as well as links to ARC (http://www.thearc.org), the Think First Foundation [National Injury Prevention Program] (http://www.thinkfirst.org) and the National Institute of Child Health and Human Development (http://www.nichd.nih.gov)) ,which provide information on other health, safety, and medical issues for children.
- The National Institute of Child Development and Human Health is a large site with excellent publications, among which are guides for helping children cope with crisis, guides on parenting, sudden infant death syndrome (SIDS), and diseases of children.
- The Kentucky Cabinet for Families and Children (http://cfc.state.ky.us) is one of the most interesting sites on SBS. Their online newsletter (February 2003) describes an essay contest for high school students and two winning entries:"Shake Your Problems, Not Your Baby" and "Why Caregivers Shake Babies and How to Prevent It." Essay writing is a good, easy, and inexpensive strategy to use on an installation to spread the word about your SBS program and to increase community awareness and interest in the problem. We recommend that you check out this site.

Research Into Practice: Gold Standard, Randomized Trials, Effectiveness, and Efficacy — What Do These Terms Mean?

James E. McCarroll, Ph.D., and Robert J. Ursano, M.D.

Research into Practice' a regular feature of *Joining Forces Joining Families*, explains aspects of research design, research concepts, and statistical tests. In this issue, we review some technical terms used in the article on Hawaii's home visiting program: *gold standard, randomized trials, effectiveness,* and *efficacy*.

The term, gold standard, in practice and research, denotes the highest possible level of value and is used for the purpose of comparison. Gold standard comes from the field of economics in which gold once represented (and sometimes still does) the monetary value of a country. In scientific research and practice, the gold standard is used to convey that which the researcher or practitioner holds up as the best means of measurement. While an autopsy might be considered the gold standard for findings related to pathology, an x-ray, MRI or CAT scan would be a radiologist's gold standard for diagnosis. In other words, one person's gold standard might not be another's gold standard! A gold standard test is not infallible, just the best that is known.

What is a randomized trial?

A randomized trial (sometimes also called a randomized clinical trial or a randomized controlled trial) is used in research in which the investigator wishes to test the effect of an intervention (such as a new psychotherapy or new medication). The term "randomized" comes from the fact that participants (people or families or whatever unit you wish to study) are assigned randomly to different groups. Randomization (assignment to one of the groups to be tested) is a very important process and usually involves the use of a random number table or some such mathematical guide. The importance of randomization is to ensure that the two (or more) test groups are equivalent — having no systematic differences except for the intervention. The two or more groups are then used to compare different treatments, different amounts of some treatment, one treatment with another treatment, or with no treatment. All groups are given the same outcome measures to determine whether one treatment is better than another or is better than no treatment. While the perfect randomized trial may be difficult to achieve in practice, it is still generally the only accepted procedure that is recognized and approved by the FDA and other government agencies as demonstrating that a treatment works. It may not always be possible to perform a randomized trial for ethical or other reasons. For a definition of randomized clinical trials and other clinical terms see *http://www.cancer.gov/dictionary.*

What is the difference between an effectiveness study and an efficacy study?

The evaluation of home visiting reported in this issue of *JFJF* is an effectiveness study. An *effectiveness* study is one in which the procedure (typically psychotherapy, but in this case home visiting) is tested *as it is actually performed in the field*. The efficacy study is conducted very differently. Efficacy studies are used to test if a specific procedure has any therapeutic value under ideal conditions. In an efficacy study, as many variables as possible are controlled. The experiment is done in a more rigorous manner with substantiated exclusion and inclusion criteria resulting in highly selected participants. In both types of study therapeutic procedures are standardized and made explicit, often by putting them in a treatment manual. (This is called manualization of the therapy.) The therapist then follows the treatment manual, which indicates what is to be done in each session and the number of sessions. In an efficacy study, the fidelity of the therapist (how well he or she is following the procedure) is documented. The results are analyzed by a person who does not know whether the participant was in the treatment condition or the control condition. If the outcome of an efficacy study of an intervention shows that the intervention group did better than the control group over a number of trials, the procedure can be identified as empirically supported therapy. Whether the procedure investigated in the efficacy study actually works in practice, which includes the vagaries of the intervention, has to be tested in an effectiveness study (i.e., in the field).

Home visiting has shown positive benefits and remains a promising opportunity for decreasing child maltreatment. It also has the potential for increasing the involvement of fathers in family and community programs and for reaching young mothers who might be socially isolated in remote military communities.

***Home Visiting**, from page 3*

- Universal programs (targeting all families rather than selecting high-risk families) may be an inefficient use of resources, as many of these families may never mistreat their children.
- The effectiveness of home visiting has not yet been demonstrated. Further study is needed to document which elements of home visiting programs work for which families and for which problems.
- Home visiting programs should not be considered proven models that can be taken off the shelf and be reliably expected to reduce maltreatment. They might better be considered interventions still requiring testing and development.

Further research should be directed to:[1]

- *Study home visiting in a more sophisticated way*. The elements for more direct study include home visitor communication skills, visit content, and service quality.
- *Include a range of child abuse and neglect indicators in studies* rather than relying on substantiated reports or hospitalizations to infer program success. The use of protocols and formal referral arrangements for families with multiple and complex problems would help the home visitors focus on the most important problems rather than trying to solve all the needs of the families.
- *Have clear goals and tested models for research* that can provide essential information that will improve the effectiveness of the programs.
- *Implement and study a variety of home visiting models* and programs as well as a variety of home visiting research efforts.
- *Have control groups* since studies purportedly showing program effectiveness in uncontrolled studies can be highly misleading. Historically, many home visiting programs show improvement in parental risk factors in families, but so did control families. Without the control comparisons, program success is assumed rather than demonstrated and is ultimately harmful to the program and the families.
- *Integrate home visiting into a larger array of community services.* In the Army this could be an easy task, but its effect on child maltreatment must be documented. Such a project is potentially more feasible in the Army than in the civilian community due to the concentration of on-post services. However, integrating service delivery with the outside community is more difficult. Nevertheless, in order to determine where families go for help and whether such help is effective in reducing child maltreatment and parents' risk levels remains to be demonstrated.
- *Study the effects of participant attrition.* In the work reported here, about half the study families dropped out by the end of the first year.[1] (There was no difference in attrition between study and control groups.) Understanding the reasons for program dropout has potentially important implications for program success. An important project that could be undertaken by the Army is to relate program attendance and participation to dropout rates and other measures of the success of home visiting programs.
- *Study father involvement.* Father involvement was found to be low in these studies even though about two thirds of fathers had been assessed as being at-risk of perpetrating child abuse. The Army has a much greater opportunity to involve active duty fathers in home visiting programs than does the civilian community. Research opportunities abound in this area, as there is essentially no literature on the effects of such programs on fathers.
- *Focus the efforts of home visitors on the risk factors that can be modified.* This requires the home visitor to learn the proximate causes of child maltreatment, relate them to parent and child risk factors, and develop a plan to address them. Supervision, training, and ongoing monitoring of the home visitor appear to be critical elements of any home visiting program. While getting from plan to goal may be difficult to demonstrate, it is entirely possible for home visitors to document observations and their attempts to address the risk factors within the families.

Home visiting offers promise, but requires

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further study. The point of this review is to stimulate research and management interest in improving home visiting programs and making them cost-effective. Home visiting has shown positive benefits[8] and remains a promising opportunity for decreasing child maltreatment. It also has the potential for increasing the involvement of fathers in family and community programs and for reaching young mothers who might be socially isolated in remote military communities. With the increasing frequency and length of overseas deployments such efforts will be important in serving military families. We hope that home visiting will receive increased research emphasis in the Army and continue to serve as a keystone of the Army's child maltreatment prevention efforts.

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